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CHAPTER V
SURGERY: RESPIRATORY, CARDIOVASCULAR, HEMIC AND LYMPHATIC SYSTEMS
CPT CODES 30000-39999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter V
Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems
CPT Codes 30000 - 39999

A. Introduction

The general guidelines regarding correct coding apply to the CPT codes in the range of 30000-39999. Specific issues unique to this section of the *CPT Manual* are clarified in the following guidelines.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, or ZZZ. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier. All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure.

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an
E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier –25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier –25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Respiratory System

1. Because the upper airway is bordered by a mucocutaneous margin, several CPT codes may define services involving biopsy, destruction, excision, removal, revision, etc. of lesions of this margin, specifically the nasal and oral

surfaces. When billing a CPT code for these services, only one CPT code which most accurately describes the service performed should be coded, generally either from the CPT section describing integumentary services (CPT codes 10040-19499) or respiratory services (CPT codes 30000-32999). When the narrative accompanying the CPT codes from the respiratory system section includes tissue transfer (grafts, flaps, etc.), individual tissue transfer/graft/flap codes (e.g., CPT codes 14000-15770) are not to be separately coded.

2. In keeping with the general guidelines previously promulgated, when a biopsy of an established lesion of the respiratory system is obtained as part of an excision, destruction, or other type of removal, either endoscopically or surgically, at the same session, a biopsy code is not to be reported by the surgeon in addition to the removal code. In the case of multiple similar or identical lesions, the biopsy code is not separately reported even if performed in a different area. As noted previously, in the circumstance where the decision to perform the more comprehensive procedure (excision, destruction, or other type of removal) is dependent on the results of the biopsy, the procedure may be separately reported. If, at the same session, a biopsy is necessary to establish the need for surgery, modifier -58 would be used to indicate this.

Example: If a patient presents with nasal obstruction, sinus obstruction and multiple nasal polyps, it may be reasonable to perform a biopsy prior to, or in conjunction with, polypectomy and ethmoidectomy; in this case a separate code (e.g., CPT code 31237 for nasal/sinus endoscopy) is not to be reported with the column one nasal/sinus endoscopy code (e.g., CPT code 31255) even though the latter code does not specifically list a biopsy in its CPT narrative because the biopsy tissue is procured as part of the surgery, not to establish the need for surgery.

3. When a diagnostic endoscopy of the respiratory system is performed, it is routine to evaluate the access regions as part of the medically necessary service; a separate service for this evaluation is not to be reported. For example, if an anterior ethmoidectomy is endoscopically performed, it is inappropriate to bill a diagnostic nasal endoscopy simply

because the approach to the sinus was transnasal. As another example, fiberoptic bronchoscopy services routinely involve a limited inspection of the nasal cavity, the pharynx and the larynx; only the bronchoscopic code is reported, not with the nasal endoscopy, laryngoscopy, etc., for this service as this service is routine and incidental to the bronchoscopy.

If a diagnostic endoscopy is performed, and this results in a decision to perform a (non-endoscopic) surgical procedure, then this endoscopy could be separately reported, indicating that this represented a distinct diagnostic service. Modifier -58 may be used to denote that the diagnostic endoscopy and the non-endoscopic surgical procedure are staged or planned procedures. Diagnostic endoscopy of the respiratory system (e.g., sinus endoscopy, laryngoscopy, bronchoscopy, pleuroscopy, etc.) performed at the same encounter as a surgical endoscopy is included in the surgical endoscopy according to *CPT Manual* guidelines. However, when an open surgical procedure is performed and, at the same session, is accompanied by a "scout" endoscopy to evaluate the surgical field, the endoscopy code is not reported separately. This policy applies either if the endoscopic procedure is to confirm the anatomical nature of the patient's respiratory system or adequacy of the surgical procedure (e.g., tracheostomy, etc.). Additionally if an attempt to perform an endoscopic procedure fails and is converted to an open procedure, the endoscopic procedure is not separately reportable with the open procedure.

Example: If a patient presents with aspiration of a foreign body and a bronchoscopy is performed indicating a lobar foreign body obstruction, an attempt may be made to remove this bronchoscopically. It would be inappropriate to code and bill for CPT codes 31622 (bronchoscopy - diagnostic) and 31635 (surgical bronchoscopy with removal of foreign body); only the "surgical" endoscopy, CPT code 31635, would be appropriate. In this example, if the endoscopic effort is unsuccessful and a thoracotomy is planned, the diagnostic bronchoscopy could be separately coded in addition to the thoracotomy. Modifier -58 may be used to indicate that the diagnostic bronchoscopy and the thoracotomy are staged or planned procedures. If the surgeon decided to repeat the bronchoscopy after induction of general anesthesia to confirm the surgical approach to the foreign body,

billing a service for this confirmatory bronchoscopy is inappropriate, although the initial diagnostic bronchoscopy could still be reported. Additionally, the failed bronchoscopic attempt to remove the foreign body should not be reported with an open procedure to remove the foreign body.

4. When a sinusotomy is performed in conjunction with a sinus endoscopy, only one service is reported. If the medically necessary service was the sinusotomy and the endoscopy was performed to evaluate adequacy or visualize the sinus cavity for disease, then the primary procedure would be best represented by the appropriate sinusotomy CPT procedure code. On the other hand, as a sinusotomy is usually required to accomplish a medically necessary diagnostic (or surgical) sinus endoscopy, the sinus endoscopy would be the primary (medically necessary) service and should be reported. *CPT Manual* narrative indicates that a surgical sinus endoscopy always includes a sinusotomy and diagnostic endoscopy.

5. Control of bleeding during a procedure is an integral part of endoscopic procedures and is not separately reported (e.g., CPT code 30901 for control of nasal hemorrhage is not to be reported with CPT code 31235 for nasal/sinus endoscopy, etc.). If bleeding is a late complication and requires a significant, separately identifiable service after the patient has been released from the endoscopic procedure, a separate service may be reported with modifier -78 indicating that a related procedure was performed to treat a complication during the postoperative period.

6. When endoscopic procedures are performed, the most comprehensive code describing the service rendered is reported. If multiple procedures are performed and not adequately described by a single CPT procedure code, more than one code may be reported; however, the multiple procedure modifier -51 is attached to the appropriate secondary service CPT codes. Additionally, only medically necessary services are reported; incidental examination of other areas are not to be separately reported.

7. When laryngoscopy is required for placement of an endotracheal tube (e.g., CPT code 31500), a laryngoscopy code is

not to be separately coded. Additionally, when a laryngoscopy is used to place an endotracheal tube for non-emergent reasons (e.g., general anesthesia, bronchoscopy, etc.) a separate service is not to be reported for the laryngoscopy. The CPT code 31500 refers only to endotracheal intubation as an emergency procedure and is not reported when an elective intubation is performed. When intubation is performed in the setting of a rapidly deteriorating patient who will require mechanical ventilation, a separate service may be reported with adequate documentation of the reasons for intubation.

8. When tracheostomy is performed as an essential part of laryngeal surgery, in accordance with the separate procedure policy, the CPT code 31600 is not separately reported. This would include laryngotomy, laryngectomy, laryngoplasty codes or other codes that routinely require placement of a tracheostomy.

9. If a laryngoscopy is required for the placement of a tracheostomy, the tracheostomy (CPT codes 31603-31614) is reported and not the laryngoscopy.

10. CPT code 92511 (nasopharyngoscopy with endoscopy) should not be reported as a distinct service when performed as a cursory inspection with other respiratory endoscopic procedures.

11. A surgical thoracoscopy is included in and not to be separately reported from an open thoracotomy when performed at the same session; the thoracotomy would represent the more extensive procedure successfully accomplished. If, however, the thoracoscopy was performed for purposes of an initial diagnosis and the decision to perform surgery is based on the results of the thoracoscopy, then it is separately reported. Modifier -58 may be used to indicate that the diagnostic thoracoscopy and the thoracotomy are staged or planned procedures.

D. Cardiovascular System

1. Procurement of a venous graft is integral to the performance of a coronary artery bypass using venous bypasses. CPT codes 37700-37735 (ligation of saphenous veins) are not to be separately reported in addition to CPT codes 33510-33523 (coronary artery bypass).

2. When a coronary artery bypass is performed, the more comprehensive code describing the procedure performed should be used. When venous grafting only is performed, only one code in the group of the coronary artery bypass CPT codes 33510-33516 (venous graft only) can be reported; no other bypass codes should be reported with these codes. One code in the group of CPT codes 33517-33523 (combined arterial-venous grafting) and one code in the group of CPT codes 33533-33536 (arterial grafting) can be reported together to accurately describe combined arterial-venous bypass. When only arterial grafting is performed, only one code in the group of CPT codes 33533-33536 (arterial grafting) is coded.

3. During venous or combined arterial venous coronary artery bypass grafting procedures (CPT codes 33510-33523), it is occasionally necessary to perform epi-aortic ultrasound. This procedure may be reported with CPT code 76986 (ultrasonic guidance, intraoperative) appending modifier -59. CPT code 76986 should not be reported for ultrasound guidance utilized to procure the vascular graft.

4. When an intervascular shunt procedure is performed as a part of another procedure at the same site requiring vascular revision, a service for a shunt procedure is not separately reported from CPT codes 36800-36861 (intervascular cannulization/shunt). By *CPT Manual* definition, this series of codes represents "separate procedures" (see separate procedure policy in Chapter I, Section J).

5. An aneurysm repair may require direct repair with or without graft insertion, thromboendarterectomy and/or bypass. When a thromboendarterectomy is undertaken at the site of the aneurysm and it is necessary for an aneurysm repair or graft insertion, a separate service is not reported for the thromboendarterectomy. Additionally, if only a bypass is placed, which may require an endarterectomy to place the bypass graft, only the code describing the bypass can be reported. If both an aneurysm repair (e.g., after rupture) and a bypass are performed at separate non-contiguous sites, the aneurysm repair code and the bypass code should be reported with an anatomic modifier or modifier -59.

If a thromboendarterectomy is medically necessary, due to vascular occlusion on a different vessel at the same session, the appropriate code may be reported, but should include an anatomic modifier or modifier -59, indicating that this represents non-contiguous vessels. At a given site, only one type of bypass (venous, non-venous) code can be reported. If different vessels are bypassed by different methodology, separate codes may be reported. If the same vessel has multiple obstructions and requires different types of bypass in different areas, separate codes may be reported; however, it will be necessary to indicate that multiple procedures were performed by using an anatomic modifier or modifier -59.

6. When an open vascular procedure (e.g., thromboendarterectomy) is performed, the closure and repair are included in the description of the vascular procedure. Accordingly, the CPT codes 35201-35286 (repair of blood vessel) are not to be reported in addition to the primary vascular procedure.

7. When an unsuccessful percutaneous vascular procedure is followed by an open procedure at the same session/same physician (e.g., percutaneous transluminal angioplasty, thrombectomy, embolectomy, etc. followed by a similar open procedure such as thromboendarterectomy), only the service for the successful procedure, which is usually the more extensive, open procedure is reported (see sequential procedure policy, Chapter I, Section M). In the case where a percutaneous procedure is performed at the site of one lesion, and an open procedure is performed at a separate lesion, the services for the percutaneous procedure should be reported with modifier -59 only if the lesions are in distinct anatomical vessels.

8. The HCPCS/CPT codes 36000, 36406, 36410, etc. represent very common procedures performed to gain venous access for phlebotomy, prophylactic intravenous access, infusion therapy, chemotherapy, hydration, transfusion, drug administration, etc. When intravenous access is routinely obtained in the course of performing other medical/diagnostic/surgical procedures, or is necessary to accomplish the procedure (e.g., infusion therapy, chemotherapy), it is inappropriate to bill separately for the venous access

services. The work of gaining routine vascular access is integral to and therefore included in the work value of the procedure. HCPCS/CPT codes 90760-90761 and C8950-C8951 should not be reported for infusions to maintain patency of a vascular access site.

9. When a (non-coronary) percutaneous intravascular interventional procedure is performed at the same session/site as diagnostic angiography (arteriogram/venogram), only one selective catheter placement code for the involved site may be reported. If the angiogram and the percutaneous intravascular interventional procedure are not performed in immediate sequence and the catheters are left in place during the interim, a second selective catheter placement or access code should not be reported. Additionally, dye injections to position the catheter should not be reported as a second angiography procedure.

10. Diagnostic angiograms performed on the same date of service as a percutaneous intravascular interventional procedure should be reported with modifier -59. If a diagnostic angiogram (fluoroscopic or computed tomographic) was performed prior to the date of the percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifier -59. If it is medically reasonable and necessary to repeat only a portion of the diagnostic angiogram, append modifier -52 to the angiogram CPT code. If the prior diagnostic angiogram (fluoroscopic or computed tomographic) was complete, the provider should not report a second angiogram for the dye injections necessary to perform the percutaneous intravascular interventional procedure.

11. When a median sternotomy is performed to accomplish cardiothoracic procedures, the repair of the sternal incision is part of the primary procedure. The CPT codes 21820-21825 (treatment of sternum fracture) are not separately reported nor should the removal of embedded wires be reported if a repeat procedure or return to the operating room (e.g., postoperative hemorrhage on the day of surgery) is necessary.

12. When existing vascular access lines or selectively placed catheters are used to procure arterial or venous samples, billing for the sample collection separately is inappropriate. CPT codes 36500 (venous catheterization for selective organ blood sampling) or 75893 (venous sampling through catheter with or without angiography…) may be reported for venous blood sampling through a catheter placed for the sole purpose of venous blood sampling with or without venography. CPT code 75893 includes concomitant venography. If a catheter is placed for a purpose other than venous blood sampling with or without venography (CPT code 75893), it is a misuse of CPT codes 36500 or 75893 to report them in addition to CPT codes for the other venous procedure(s). CPT codes 36500 or 75893 should not be reported for blood sampling during an arterial procedure.

13. Peripheral vascular bypass CPT codes describe bypass procedures using venous grafts (CPT codes 35501-35587) and using other types of bypass procedures (arterial reconstruction, composite). Because, at a given site of obstruction, only one type of bypass is performed, these groups of codes are mutually exclusive. When different sites are treated with different bypass procedures in the same operative session, the different bypass procedures may be separately reported, using an anatomic modifier or modifier -59.

14. Vascular obstruction may be caused by thrombosis, embolism and/or atherosclerosis as well as other conditions. Treatment may, therefore, include thrombectomy, embolectomy and/or endarterectomy; these procedures may be performed alone or in combination. CPT codes are available describing the separate services (CPT codes 34001 - 34203) and describing these services with thromboendarterectomy (CPT codes 35301 - 35381). Only the more comprehensive code describing the services performed for a given site can be reported; therefore, for a given site, a code from both of the above groups cannot be reported together. Additionally, in accordance with the sequential procedure policy, if a balloon thrombectomy fails, and requires a performance of an open thromboendarterectomy, only the more comprehensive service that was performed (generally the open procedure) is reported.

15. When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty alone, only the column one atherectomy procedure that was performed (generally the open procedure) is reported (see sequential procedure policy, Chapter I, Section M).

16. CPT codes 35800-35860 are to be used when a return to the operating room is necessary for exploration for postoperative hemorrhage; accordingly, these codes are not to be coded for bleeding that occurs during the initial operative session. Generally, when these codes are used, they are to be reported with modifier -78 indicating that the service represents a return to the operating room for a related procedure during the postoperative period.

17. Many Pacemaker/Pacing Cardioverter-Defibrillator procedures (HCPCS/CPT codes 33200-33249, G0297-G0300) and Intracardiac Electrophysiology procedures (CPT codes 93600-93662) require intravascular placement of catheters into coronary vessels or cardiac chambers under fluoroscopic guidance. Physicians should not separately report cardiac catheterization or selective vascular catheterization CPT codes for placement of these catheters. A cardiac catheterization CPT code is separately reportable if it is a medically reasonable, necessary, and distinct service performed at the same or different patient encounter. Fluoroscopy codes are not separately reportable with the procedures described by HCPCS/CPT codes 33200-33249, G0297-G0300, and 93600-93662. Similarly, ultrasound guidance is not separately reportable with these CPT codes. Physicians should not report CPT codes 76942, 76986, 93318, or other ultrasound procedural codes if the ultrasound procedure is performed for guidance during one of the procedures described by HCPCS/CPT codes 33200-33249, G0297-G0300, or 93600-93662.

18. CPT code 37202 (transcatheter therapy, infusion other than for thrombolysis, any type…)describes an arterial infusion of a non-chemotherapeutic medication for a purpose other than thrombolysis. This code should not be utilized to

report intravenous infusions, arterial push injections (CPT code 90773), or chemotherapy infusions.

19. The *CPT Manual* defines primary and secondary percutaneous transluminal arterial mechanical thrombectomies. The *CPT Manual* defines a secondary percutaneous transluminal arterial mechanical thrombectomy as follows: "removal or retrieval of short segments of thrombus or embolus when performed either before or after another percutaneous intervention". Based on this CPT instruction, the NCCI contains edits bundling the primary percutaneous transluminal mechanical thrombectomy (CPT code 37184) into all percutaneous arterial interventional procedures. These edits allow use of NCCI-associated modifiers if a provider performs a primary percutaneous transluminal arterial mechanical thrombectomy not in conjunction with the other percutaneous arterial procedure.

20. CPT code 37215 describes a percutaneous transcatheter placement of intravascular stent(s) in the cervical carotid artery utilizing distal embolic protection. It includes all ipsilateral selective carotid arterial catheterization, all diagnostic imaging for ipsilateral cervical and cerebral carotid arteriography, and all radiological supervision and interpretation (RS&I). Physicians should not unbundle the RS&I services. For example a provider should not report CPT code 75962 (RS&I for transluminal balloon angioplasty of a peripheral artery) for angioplasty of the cervical carotid artery which is an included service in the procedure defined by CPT code 37215. Additionally since the carotid artery is not a peripheral artery, it is a misuse of CPT code 75962 to describe a carotid artery procedure. This same principle would apply to CPT code 37216, but it is currently a noncovered service code on the Medicare Physician Fee Schedule.

E. Hemic and Lymphatic Systems

When bone marrow aspiration is performed alone, the appropriate code to report is CPT code 38220. When a bone marrow biopsy is performed, the appropriate code is CPT code 38221 (bone marrow biopsy). This code cannot be reported with CPT code 20220 (bone biopsy). CPT codes 38220 and 38221 may only be reported together if the two procedures are performed at separate sites

or at separate patient encounters. Separate sites include bone marrow aspiration and biopsy in different bones or two separate skin incisions over the same bone. When both a bone marrow biopsy (CPT code 38221) and bone marrow aspiration (CPT code 38220) are performed at the same site through the same skin incision, do not report the bone marrow aspiration, CPT code 38220, in addition to the bone marrow biopsy (CPT code 38221). HCPCS/CPT code G0364 may be reported to describe the bone marrow aspiration performed with bone marrow biopsy through the same skin incision on the same date of service.

F. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration

(CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Drug administration services (CPT Codes 90760-90775) are not separately reportable by the physician performing an operative procedure for drug administration during the operative procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report HCPCS/CPT codes C8950-C8952, 90772 or 90773 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. HCPCS/CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (HCPCS/CPT codes 90760-90775, C8950-C8952) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (HCPCS/CPT codes 90760-90775, C8950-C8952) may be reported with an NCCI-associated modifier.

4. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for

the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

5. Open procedures of the thoracic cavity require a thoracotomy for the surgical approach. A physician should not report CPT code 32100 (thoracotomy, major; with exploration and biopsy) in addition to an open thoracic procedure CPT code.

6. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.